Dental Evaluation Form

Are you having any **problems** with your teeth/gums? Yes No
If so, please describe_____

Are you happy with the **appearance** of your teeth/gums/smile? Yes No
If no, what would you like to improve? _____

_____

Do you have any issues with TMJ (jaw) or grind/clenching? Yes No

New patients only: When was the last time you saw a dentist? _____